LUXDENTICA
CENTRUM STOMATOLOGII

PATIENT PERSONAL QUESTIONNAIRE

Personal data

First name and Surname:	PESEL:
Address:	Date of birth:
Mobile phone:	E-mail:

Would you like to receive promotional information regarding Luxdentica services?

I do not agree with my medical records being shared with third parties (signature):

Person authorised to receive information concerning your health, the healthcare provided and to obtain medical records _____ phone number: _____

Guarantee of our services

We provide a service warranty:

1. 20 years for Premium Implants and 10 years for Otimum Implants
2. 3 years for root canal treatment
3. 3 years for any fixed prosthetic restorations (crowns, bridges, veneers)
4. 2 years for fillings
5. 1 year for removable dentures

Conditions for maintaining the warranty:

1. regular check-ups every 12 months and dental hygienic treatment with one of our hygienists, including determination of API, PBI hygiene indexes (paid services)
2. check up visits every 3 months after completion of orthodontic treatment
3. following the recommendations of the doctor
4. maintaining good oral hygiene

The warranty does not cover:

1. temporary work such as: temporary crown, temporary dentures fitted immediately after tooth extraction
2. work where the patient has been informed of a limited or no warranty and which has been carried out at the patient's request
3. when root canal treatment is necessary immediately after filling the tooth, the filling is done under warranty and the patient covers the costs of the root canal treatment
4. root canal retreatment
5. root canal treatment without a microscope
6. treatment of deciduous teeth

The warranty will be invalid as a result of:

1. insufficient oral hygiene
2. fracture of dental crowns between visits for teeth undergoing root canal treatment
3. fractures of crowns of teeth after root canal treatment not prosthetically restored
4. failure to attend to recommended check-ups
5. mechanical damage
6. natural bone loss and periodontal changes
7. existing medical conditions that affect the masticatory system such as: diabetes, epilepsy, osteoporosis, radiation and cytostatic therapy

I declare that the above conditions are clear and understandable. At the same time, by failing to comply with the above guarantee conditions, I waive my right to claim against Luxdentica. I agree to the treatment by signing.

_____

Signature of the patient (legal guardian)

Heath Questionnaire

Below information is only provided to your dentist/s

Lp.	Do you receive any medical treatments/ taking medicines on?	YES	NO
1.	hypertension		
2.	hipotension		
3.	heart disease or any problems with your circulatory system		
4.	liver disease		
5.	rheumatism		
6.	any kind of eye disease		
7.	hormonal disfunction		
8.	peptic ulcer		
9.	epilepsy		
10.	asthma, hay fever or any allergic symptoms		
11.	gland disease		
12.	diabetes		
13.	cancer disease		
	Have you ever had?	**YES**	**NO**
1.	heart attack		
2.	heart operation		
3.	Stroke		
4.	Hepatitis type B		
5.	Hepatitis type C		
	Have you had any surgery in the last 2 years, if yes, what kind?		
	Do you bleed extensively?		
	Have you ever been diagnosed?	**YES**	**NO**
1.	HBS positive		
2.	HIV positive		
	Are you allergic on?	**YES**	**NO**
1.	medicines		
2.	dental products		
3.	any food		
4.	other		
	Have you ever had any other diseases?		
	Do you take any other medicines, if yes, what kind?		
	Are you pregnant?		

I acknowledge the truth of information in this health questionnaire with my signature. I promise to inform my dentist on any changes to my health situation.

Signature of the patient (legal guardian)

Place, date